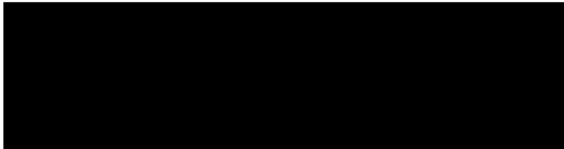


STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

FILED

FEB 04 2015

OFFICE OF APPEAL HEARINGS
DEPT OF CHILDREN & FAMILIES



APPEAL NO. 14F-09565

PETITIONER,

Vs.

CASE NO. 


FLORIDA DEPT OF CHILDREN AND FAMILIES
CIRCUIT: 06 Pinellas
UNIT: 88269

RESPONDENT.

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on December 15, 2014 at 1:00 p.m. All parties appeared in different locations by phone.

APPEARANCES


For Petitioner:  petitioner

For Respondent: Anjali Pant, Senior Human Service Program Specialist

STATEMENT OF ISSUE

At issue is whether respondent's action in denying petitioner's application for SSI-Related Medicaid is correct.

PRELIMINARY STATEMENT

Petitioner was present and testified. He presented one witness who testified: , petitioner's mother. Petitioner did not submit any documentary evidence at the hearing.

The respondent was represented by Anjali Pant with the Department of Children and Families (hereafter "DCF", "Respondent" or "Agency"). Respondent submitted six exhibits, which were accepted into evidence and marked as Respondent's Exhibits "1" through "6".

The record was left open until December 22, 2014 to allow the respondent and the petitioner the opportunity to provide additional documentation. The respondent submitted a Disability Determination and Transmittal form; a signed Authorization to Disclose Information form; and an email indicating the meaning of code 11. The documentation was marked and entered as Respondent's Exhibit "7". Petitioner submitted medical records from various sources. The documentation was entered and marked as Petitioner's Exhibit "1".

FINDINGS OF FACT

Based upon the oral and documentary evidence presented at the final hearing and on the entire proceeding, the following Findings of Fact are made:

1. Petitioner is a 36-year-old male who has the medical diagnoses of Anxiety, Cirrhosis, venous thromboembolus, Esophageal varices in cirrhosis, Hepatitis C, Hypothyroid, and Pancreatitis. He also has seven bands in his esophagus and bleeds internally.
2. Petitioner's most recent Social Security Administration's (SSA) application was denied in January 31, 2014 with the unfavorable decision of (N36). Decision code N36 indicates insufficient or medical data furnished. Petitioner did not submit the January 2014 SSA denial letter into evidence.

3. Petitioner's mother initially completed petitioner's initial SSA application and the health care providers did not send any medical documentation to SSA. He has retained an attorney to assist him with SSA appeal. Petitioner is currently waiting for a court date to have his "compassion benefits" approved.

4. Petitioner submitted an application for SSI-Related Medicaid benefits prior to his September 10, 2014 application. The date of the first application is unknown.

5. On June 13, 2014, the respondent submitted petitioner's information and the Disability Determination and Transmittal form to the Department of Health's Division of Disability Determinations (DDD).

6. On June 20, 2014, DDD submitted the Disability Determination and Transmittal form to the respondent. DDD determined petitioner not disabled using code N32; has a primary diagnosis of "11"; and denied petitioner's Medicaid application on June 18, 2014 pursuant to Hankerson. Code N32 means "Non pay – Capacity for substantial gainful activity – customary past work, no visual impairment. "Code 11 is body system that corresponds with Social Security body system". The specific body system considered as "code 11" is unknown.

7. On September 10, 2014, petitioner submitted an application for SSI-Related Medicaid on the basis of disability.

8. On September 16, 2014, the respondent mailed petitioner a Notice of Case Action that indicated his September 10, 2014 Medicaid application was denied as "you or a member(s) of your household do not meet the disability requirement".

9. Petitioner's two SSI-Related Medicaid applications were denied because SSA rendered an unfavorable decision within one year of petitioner's Medicaid applications.

Respondent asserted that DDD will not conduct an independent review unless petitioner has evidence of a new condition not considered by SSA.

10. Respondent asserted petitioner is not eligible for Family-Related Medicaid as he has no children under the age of eighteen living with him; and is not eligible for SSI-Related Medicaid as he is under the age of 65 and has not been found disabled by either SSA or DDD.

11. Petitioner currently does not receive any medications or treatment for his medical diagnoses, as he cannot afford the physician visits or medical treatments. He requires medical treatment for the bands in his esophagus.

12. Petitioner asserted he requires Medicaid as he has almost died because of his illnesses and is frequently hospitalized because of them.

13. Petitioner believed SSA did not have any medical diagnoses when it initially denied his SSA application. Although, petitioner's initial SSA application was denied due to lack of medical records, petitioner's attorney has all of his medical records that have not been submitted to SSA.

CONCLUSIONS OF LAW

14. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Fla. Stat § 409.285. This order is the final administrative decision of the Department of Children and Families under § 409.285, Fla. Stat.

15. This proceeding is a de novo proceeding pursuant to Florida Administrative Code § 65-2.056.

16. In accordance with Fla. Admin. Code § 65-2.060 (1), the burden of proof for petitioner's Medicaid appeal is assigned to the petitioner.

17. The standard of proof needed to be met in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed., 1999), or evidence that "more likely than not" tends to prove a certain proposition. See Gross v. Lyons, 763 So. 2d 276, 289, n.1 (Fla. 2000).

18. The Fla. Admin. Code R. 65A-1.705(7)(c) Family-Related Medicaid General Eligibility Criteria, in part states:

If assistance is requested for the parent of a deprived child, the parent and any deprived children who have no income must be included in the SFU. Any deprived siblings who have income, or any other related fully deprived children, are optional members of the SFU. If the parent is married and the spouse lives in the home, income must be deemed from the spouse to the parent. For the parent to be eligible, there must be at least one child under age 18, with or without income, in the SFU, or who would be in the SFU if not receiving SSI...

19. According to the above authority, to be eligible for retroactive Family-Related Medicaid, petitioner must have a minor child under age 18 living in the household with him. Since petitioner does not have any children under the age of 18 living in the home, he does not meet the technical requirement to be eligible for Family-Related Medicaid benefits.

20. Fla. Admin. Code R. 65A-1.710 sets forth the rules of eligibility for SSI-Related Medicaid Coverage Groups. The MEDS-AD Demonstration Waiver is a coverage group for aged and disabled individuals (or couples), as provided in 42 U.S.C. § 1396a(m). For an individual less than 65 years of age to receive benefits, he or she must meet the

disability criteria of Title XVI of the Social Security Act appearing in 20 C.F.R. § 416.905 and states, in part:

(a) The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. To meet this definition, you must have a severe impairment(s) that makes you unable to do your past relevant work (see § 416.960(b)) or any other substantial gainful work that exists in the national economy.

21. Federal Regulation at 42 C.F.R. § 435.541 provides standards for state disability determinations and states in relevant part:

Determinations of disability.

(a) Determinations made by SSA. The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability.

....

(2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.912 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided for under §435.909.

(b) Effect of SSA determinations. (1) Except in the circumstances specified in paragraph (c)(3) of this section—

(i) An SSA disability determination is binding on an agency until the determination is changed by SSA.

(ii) If the SSA determination is changed, the new determination is also binding on the agency.

(2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination, except in cases specified in paragraph (c)(4) of this section.

(c) Determinations made by the Medicaid agency. The agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist:

(1) The individual applies for Medicaid as a non-cash beneficiary and has not applied to SSA for SSI cash benefits, whether or not a State has a section 1634 agreement with SSA; or an individual applies for Medicaid and has applied to SSA for SSI benefits and is found ineligible for SSI for a reason other than disability.

(2) The individual applies both to SSA for SSI and to the State Medicaid agency for Medicaid, the State agency has a section 1634 agreement with SSA, and SSA has not made an SSI disability determination within 90 days from the date of the individual's application for Medicaid.

(3) The individual applies to SSA for SSI and to the State Medicaid agency for Medicaid, the State does not have a section 1634 agreement with SSA, and either the State uses more restrictive criteria than SSI for determining Medicaid eligibility under its section 1902(f) option or, in the case of a State that uses SSI criteria, SSA has not made an SSI disability determination in time for the State to comply with the Medicaid time limit for making a prompt determination on an individual's application for Medicaid.

(4) The individual applies for Medicaid as a non-cash beneficiary, whether or not the State has a section 1634 agreement with SSA, and—

(i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or

....

(iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act, and—

(A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or

(B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility.

22. Furthermore, Memorandum dated January 31, 2002, shows in pertinent part:

In addition, staff must adopt (without requesting an independent state disability decision from the Division of Disability Determination, DDD) SSA's denial decisions on the basis of disability, unless the applicant has a new condition or SSA has refused to consider the applicant's worsened condition. **However, it is inappropriate to adopt SSA's denial decisions that are based on non-disability related factors.** For example, John Smith's notice indicates either a denial reason code of *NO1* or *NO4*. These reason codes indicate Mr. Smith was denied SSI cash assistance due to income (*NO 1*) or assets (*NO 4*) that exceeded the Title XVI income/resource standards. Generally, Social Security will not complete a disability determination when it is obvious the individual's income or resources exceeds the SSI standards.

23. SSA Program Operations Manual System (POMS), DI 11010.075, Initial Title II Technical Denials and Claims Not Requiring a Disability Determination lists the SSA technical denials as Insured status requirements not met; earnings discrepancies; alleged onset date (AOD) after date last insured (DLI); claim for disability benefits filed after death; established onset date after DLI; Claimant does not wish to pursue the claim or whereabouts are unknown; claimant dies before claim sent to Disability Determination Services (DDS); claimant dies during waiting period; disability applications filed by retirement or survivor insurance claimants; and res judicata denials
24. Petitioner was denied SSA disability benefits on January 31, 2014 pursuant to code N36; however, DDD adopted deemed petitioner not to be disabled using code N32. Both N36 and N32 are not SSA technical denials so pursuant to the above authorities, the respondent is allowed to determine if it is able to adopt SSA's denial decision and deny petitioner's application for SSI-Related Medicaid benefits.
25. Petitioner currently has retained an attorney as he is appealing his SSA denial; therefore, SSA is reconsidering its denial of petitioner's SSA application through its appeal process. There is insufficient evidence that verifies the medical diagnoses

considered by SSA in their denial decision, so it is not known if petitioner has any new or worsening conditions not previously considered by SSA. Under these circumstances, the controlling authorities preclude the respondent from rendering an independent disability determination. Accordingly, the SSA federal determination remains binding on the respondent.

26. In careful review of the cited authorities and evidence, the undersigned concludes that petitioner has not meet his burden of proof to indicate the respondent was incorrect to deny his September 10, 2014 application for SSI-Related Medicaid benefits.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is DENIED.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

FINAL ORDER (Cont.)
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DONE and ORDERED this 4th day of FEB, 2015,

in Tallahassee, Florida.

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Copies Furnished To: [REDACTED] Petitioner
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